MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF SPECIAL HEALTH CARE NEEDS

ENROLLMENT INFORMATION

READ INSTRUCTIONS ON REVERSE FIRST. PLEASE PRINT LEGIBLY IN BLACK INK.

☐ INITIAL CONTACT
☐ REFERRAL DATE _____
☐ APPLICATION DATE _____
DCN

SECTION A - PARTICIPANT INFORMATION (Individual being enrolled for services)

1. NAME (LAST, FIRST, MIDDLE)	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
4. ADDRESS (STREET, CITY, STATE, ZIP)	5. COUNTY	6. HOME TELEPHONE
	7. SEX / 8. RACE	9. PARTICIPANT/FAMILY DAYTIME PHONE
10. LOCAL PHYSICIAN NAME AND ADDRESS	11. SPECIALIST PHYSICIAN NAME AND ADDRESS	

12. SOURCE OF REFERRAL (CHECK ONE)
☐ PHYSICIAN ☐ HOSPITAL ☐ STATE AGENCIES ☐ MEDICAID/EPSDT ☐ COMMUNITY ☐ SELF/FAMILY/FRIEND ☐ OUT OF STATE

SECTION B - FAMILY INFORMATION (LIST ALL PERSONS BESIDES PARTICIPANT LIVING IN HOUSEHOLD AND DEPENDENT UPON INCOME)

13. NAME (LAST, FIRST, MIDDLE)	14. SOCIAL SECURITY NO.	15. DATE OF BIRTH	16. RELATIONSHIP	17. ON BSHCN
PARENTS:				
OTHERS:				

18. DOES THE PARTICIPANT HAVE A COURT APPOINTED GUARDIAN/CUSTODIAN?
☐ YES ☐ NO IF YES, PLEASE GIVE COMPLETE NAME AND ADDRESS ▸

NAME AND ADDRESS

19. ALTERNATE CONTACT NAME AND ADDRESS	20. TELEPHONE NUMBER

SECTION C - FINANCIAL RESOURCES

21. INCOME SOURCE (CHECK ALL THAT APPLY)
☐ SSI ☐ SSDI ☐ GENERAL RELIEF ☐ EMPLOYER ☐ VETERAN'S ADMINISTRATION ☐ SELF EMPLOYED ☐ OTHER _____

22. Did you file Federal/State Income Tax Form? ☐ YES ☐ NO
If yes, List amount of adjusted gross income from 20_____ Income Tax Form $ _____
Attach a copy of the Income Tax Form. Do Not Send W-2. If no copy available, you should obtain duplicate by calling 800/829-1040 and send when received.
If No, Why did you not file? ☐ not required to file ☐ requested extension of filing date (attach copy) ☐ Other _____

23. Has family income changed since filing Income Tax? ☐ YES ☐ NO Date of Change _____ Estimate this year's current income _____

24. Did you receive or pay child support payments? ☐ YES ☐ NO Total amount received yearly $_____ Total amount paid yearly $ _____

25. INSURANCE STATUS (CHECK ALL THAT APPLY)
☐ NONE ☐ MEDICAID # _____ ☐ MEDICARE # _____ ☐ PRIVATE INSURANCE (NAME) _____
☐ VETERAN'S ADMINISTRATION ☐ OTHER (PLEASE SPECIFY) _____ POLICY # _____ EFFECTIVE DATE _____

SECTION D - MEDICAL CONDITION OR PROBLEM

SECTION E - SERVICES REQUESTED/NEEDED

SECTION F - AUTHORIZATION TO RELEASE INFORMATION

Application is made for admission of the above named participant to the Bureau of Special Health Care Needs Section 201.040 & 191 RSMo. I authorize BSHCN to release or obtain information to or from any agencies which are participating in the treatment and care plan for the applicant. The information on this application form may be exchanged with agencies that administer relevant or applicable programs. I consent to the release of personal, financial, and medical information from this application form and supporting documents to the agencies that administer relevant or applicable programs for establishing and verifying eligibility and for performing evaluations. I understand that the agencies that administer such programs will maintain confidentiality of this information according to the applicable laws. I have been informed that BSHCN provides care on a nondiscriminatory basis as required by Title VI of the Civil Rights Act of 1964. I understand BSHCN eligibility will not be considered until all information has been received by the BSHCN area office. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in repaying in cash the value of benefits received. I understand any medical insurance benefits I may receive for services authorized by BSHCN may be forwarded to the provider of service(s). I must cooperate with the providers of services and BSHCN in giving all information concerning trust funds, legal actions, settlements and third party payors i.e., medical insurance, Medicaid, etc. I understand if I receive money from a third party or insurance related to the injury, disability or disease, Children with Special Health Care Needs shall be reimbursed for the amount expended. I have been advised and understand my rights and responsibilities under BSHCN. All the information I have provided is correct to the best of my knowledge.

27. SIGNATURE OF PARENT/GUARDIAN	28. SIGNATURE OF PARTICIPANT 18 OR OLDER	29. DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF SPECIAL HEALTH CARE NEEDS (BSHCN)

ENROLLMENT INFORMATION

READ INSTRUCTIONS BEFORE COMPLETING FORM

SECTION A - PARTICIPANT INFORMATION (Individual being enrolled for services)

1. Enter participant's name (last, first, middle).
2. Enter participant's date of birth.
3. Enter participant's Social Security number.
4. Enter address (street, city, state, zip) where participant lives.
5. Enter county where participant lives.
6. Enter telephone number where participant lives.
7. Enter participant's sex.
8. Enter participant's race (W - White, B - Black, A - Asian, NA - Native American, H - Hispanic,) - Other/Pacific Islander).
9. Enter participant/family daytime/work telephone number.
10. Enter local physician name and address where participant receives his/her basic care (immunizations, etc.).
11. Enter physician name and address where participant receives his/her specialized care.
12. Source of referral - check the box which best describes the person, agency, etc., that suggested you contact BSHCN for assistance. Physician, Hospital, Medicaid/EPSDT, State Agency (Department of Health and Senior Services, Department of Social Services, Department of Mental Health, etc.), Community (Private agency, school, local health department, etc.), self/family/friend, or out of state.

SECTION B - FAMILY INFORMATION - LIST ALL PERSONS BESIDES PARTICIPANT LIVING IN HOUSEHOLD

13. Enter name of other individuals living in same household as participant. Adult participants need not list parent(s) names.
14. Enter Social Security number of other individuals living in the same household as participant.
15. Enter Date of Birth of other individuals living in the same household as participant.
16. Enter Relationship of other individuals living in the same household with the participant.
17. If this individual receives services from the Bureau of Special health Care Needs (BSHCN) check the "BSHCN" column.
18. If the participant has a court appointed guardian/custodian check "Yes" and enter their name, address, and telephone number.
19. Enter name and address of an alternate contact - someone not in this household who will know how to get in touch with you.
20. Enter telephone number of alternate contact person.

SECTION C - FINANCIAL RESOURCES

21. Income Source - Check the box(es) which describe your source of income.
22. Check "Yes" if you filed a Federal/State Income Tax Form and list adjusted gross income. Attach a copy of the Federal/State Income Tax Form. **DO NOT SEND A W-2 FORM.** If you do not have a copy of the Income Tax Form call (800) 829-1040 to obtain an IRS 1722 Letter. Mail IRS 1722 Letter to the area office when it is received.
    Check "No" if you did not file a Federal/State Income Tax Form and indicate the reason you did not file. (Attach copy of extension.)
23. Check "Yes" if the family income has changed since filing Income Tax. If income has changed, give date of change and enter this year's estimated income.
24. Check "Yes" if you received or made child support payments. Indicate the amount received or paid this year.
25. Insurance Status - Check the box(es) which describes your insurance status, and include policy number and effective date.

SECTION D - MEDICAL CONDITION OR PROBLEM

Describe medical condition or problem the participant is having.

SECTION E - SERVICES REQUESTED/NEEDED

26. Enter services desired.

SECTION F - AUTHORIZATION TO RELEASE INFORMATION AND APPLICANT SIGNATURE - MUST SIGN AND DATE HERE BEFORE THE APPLICATION WILL BE PROCESSED.

27. Signature of Parent/Guardian
28. Participant eighteen (18) or older must sign the application. Parent/Guardian must sign along with participant eighteen (18) years or older when participant is listed on parent's Federal/State Tax form as a dependent.
29. Enter date of participant/guardian Signature.